

GID and Gender Dysphoria – Variance or Pathology?

An Honors Thesis (HONRS 499)

by

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A handwritten signature in black ink that reads "Heather Adams". The signature is written in a cursive, flowing style.

Ball State University

Muncie, IN

September 2012

Expected Date of Graduation

July 2012

SPC011
Undergrad
Thesis
LD
2489
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Project Rationale

For my honors thesis, I explored the discussion in the field of Psychological Science over the current and prospective Diagnostic and Statistical Manual of Mental Disorders (DSM) and the growing concern over existing biases and prejudices in that manual. Particularly, I focused on how gender identity disorder is presented in the text. For research, I examined articles and textbooks discussing gender identity formation and gender-related disorders, notes from courses that cover and discuss gender identity, gender identity disorders, and gender discrimination (i.e. Psychology of Gender, Abnormal Psychology, Sociology of Gender, Psychology of Sexual Behavior, etc.), formalized complaints and documents to the committee of the DSM regarding past and future issues for the current and prospective versions, and conducted interviews with individuals who specialize in areas of psychology that focus on sexuality, victimization, and trauma and abuse.

The purpose of this project is to examine this particular diagnosis in the DSM, and the social implications this may have. Inherently with a mental disorder is a social stigma, which could cause further psychological stress to the diagnosed individual. Though this may be due to my own ignorance of the topic, I wanted to inquire whether the existence of this medical diagnosis is beneficial to someone who would identify as transgender or whether it would further alienate that individual. I also wanted to discuss the proposed changes for the prospective DSM in relation to gender identity disorder, which should be released around 2013. These changes not only have gender and cross-cultural issues, but validity ones as well. These concerns have not only been addressed in behavioral science courses I have taken at Ball State University, but also by a formalized

Project Rationale

complaint from the Society of Indian Psychologists to Dr. David M. Kupfer, M.D., which is attached to this document and the original basis for my thesis.

My thesis is a thematic analysis. I wanted to complete this project to further my own understanding of how a minority population, i.e. the LGBT community, is affected by the DSM and what implications and consequences the gender identity disorder diagnosis could potentially have. I also wanted to see how experts in my field have formed their specific opinions related to these issues and what resources they have to substantiate their perspective. This broadened my familiarity with the DSM and also gave me experience in interviewing various faculty members at the university who are more qualified to speak about gender disorders and evaluate the DSM from a professional and multicultural viewpoint. This also allowed me to further develop interview experience and conduct qualitative research.

I created this project for those studying psychology to realize that our discipline is not unaffected by prejudice. I expect that they will learn that the field has varying opinions in regards to the most widely used classification system of mental pathologies.

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Abstract

This study takes a look at the Diagnostic and Statistical Manual's (DSM) Gender Identity Disorder (GID) diagnosis, in addition to the prospective Gender Dysphoria diagnosis from the DSM-V. Possible treatments were also examined. Sources included advocates and critics of the diagnosis, particularly noting the reasoning and possible consequences of it. Methodology limitations were stressed as well. The author noted differences in language use and perceived intent of each source, which could vary according to the target audience of the reference. Most important is the mixed literature surrounding this topic.

Keywords: Gender Identity Disorder, DSM, psychopathology, gender

Acknowledgements

I would like to thank Dr. Heather Adams for providing invaluable guidance throughout this project. Her advice and feedback for this thesis played a critical role in its completion. I would also like to thank Dr. George Gaither for his time and contribution to this assignment. His information gave a unique perspective, which allowed for me to realize the complexity of the issues addressed in this paper.

Purpose of Initial Study

The purpose of this study was to explore, in depth, both the current diagnosis of Gender Identity Disorder (GID) from the Diagnostic and Statistical Manual of Mental Disorders-IV Text Revision (DSM-IV-TR) and the future diagnosis of Gender Dysphoria in the prospective DSM-V. The DSM is the most widely used classification system of mental pathologies in the United States. Due to the pre-existing stigma associated with mental illness, entries in the DSM can be considered controversial. Critics of the DSM question the methodology, ethicality, and possible bias associated with various disorders. This study will examine both proponents and critics of the GID diagnosis. Additionally, to better understand the impacts of such a diagnosis, various treatments will also be explored.

Initial Data Sources and Collection of Data

Initial data sources included both critics and proponents of the GID diagnosis. Majority of the sources were web pages of various organizations, such as the GID Reform Advocates, Human Rights Campaign (HRC), the Society of Humanistic Psychology, and The Bilerico Project. These sites condemned the diagnosis, saying that the distress of gender variant or non-conforming individuals is from prejudice itself (GID Reform Advocates, 2008a; GID Reform Advocates, 2008b; Human Rights Campaign [HRC], 2009; Winters, 2008).

Diagnostic criteria for the current diagnosis for the DSM-IV-TR was found on the website for the GID Reform Advocates and also Behavenet.com. Information was also gathered on the Gender Dysphoria diagnosis from the American Psychiatric Association's (APA) DSM-V Revision website. This gave the criteria for the new diagnosis for the prospective DSM. Conversely, a formalized complaint from the Society of Indian Psychologists was reviewed.

This critique questioned the methodology and research that the Task Force for the DSM is using to update the manual.

Additionally, an interview was conducted with a psychology professor from Ball State University (BSU), Dr. George Gaither. Dr. Gaither researches sexuality and is also a counselor at BSU's Counseling Center. The interview was a structured-type interview, though follow-up questions occurred during the interview. Questions were submitted to the supervisor of this project, Dr. Heather Adams, prior to the interview to avoid any ethical issues, much like questions are submitted to an institutional review board (IRB) for other studies. Questions were also submitted to Dr. Gaither prior to the interview in order to ensure full preparedness. The interview primarily focused on typical treatment for GID, but also addressed the concerns brought up from sources such as the GID Reform Advocates, the HRC, the Society of Humanistic Psychology, and the Society of Indian Psychologists (see Appendix E).

Finally, notes were examined from courses in BSU's curriculum, such as Abnormal Psychology, Psychology of Gender, and Sociology of Gender. Textbooks used in these courses, *Women, Gender & Psychology* (Crawford, 2012) and *Human Sexuality: Diversity in Contemporary America, 7th Edition* (Yarber, Sayad, & Strong, 2010) were also investigated. These sources included details over psychopathology, treatment, gender socialization, and gender roles in our society.

Information from all of the listed sources focused primarily on the diagnosis of GID, treatments, research related to GID or its treatments, and perceived outcomes of the diagnosis. Additional focuses included basic terminology around sex and gender, particularly how society defines gender and the gender socialization process. Web pages were printed and organized

through coding. Notes and textbook information was copied verbatim from the original source before analysis as well.

Revised Purpose

Upon initial review of the sources, there was a conflict over whether the GID diagnosis allowed or limited access to treatments, as well as examples when treatments would be inappropriate. Additionally, not much was known about the treatment process for children.

Thus, the purpose of this study was to continue examining this diagnosis, contacting an insurance provider to see which associated treatments were or were not covered, and to find information about the treatment of children and instances where specific treatments are considered unsuitable. Additionally, a new goal was to develop an informed interview that would be usable with a client experiencing GID. This can only be done with further knowledge on the topic. Kvale (1996) reinforces this by stating an interviewer must have:

extensive knowledge of the interview theme, can conduct an informed conversation about the topic; being familiar with its main aspects the interviewer will know what issues are important to pursue, without attempting to shine with his or her extensive knowledge” (p. 148).

Individuals with first-hand experience would offer invaluable perspective to understanding GID.

Additional Data Sources and Collection of Data

Additional data sources were correspondence with Brandi McGlothlin, Manager of Employee Benefits at BSU, the film *Hedwig and the Angry Inch*, and Zucker and Bradley’s *Gender Identity Disorder and Psychosexual Problems in Children and Adolescence* (1995).

Brandi McGlothlin addressed BSU's insurance plans for its employees. Though BSU's insurance plan is not representative of all insurance plans, this allowed me to see which treatments would and would not have coverage. Data was collected through email correspondence. *Hedwig and the Angry Inch* was analyzed using audio coding. This film detailed why medical surgery, a common treatment sought by individuals with GID, is not appropriate in all cases. Relevant excerpts from Zucker and Bradley's (1995) text were copied verbatim and coded. The sections included treatment with child clients and research about the diagnosis.

Data Analysis

Sources were analyzed in this study using a coding process that highlighted important factors across references including: how GID was defined or referenced (using the DSM-IV-TR or DSM-V definition or referring to social norms, prejudice, or GID in another manner), information over treatment factors (such as onset of diagnosis, environment information, etc.) or specific treatment (psychotherapy, hormone therapy, sexual reassignment surgery, or other), reference to the development of a client (gender, physical, or social), reference to research cited for GID or its treatment, the type of language used in each source (positive, negative, or neutral), and the perceived intent of the reference based on how information was presented. Information was then sorted into topics of interest for this study: recommended treatments, types of treatments, criteria for diagnosis and treatment, and outcomes.

Types of Treatments

Psychotherapy. As with any other psychopathology, treatment for GID depends on the individual client and their needs (G. A. Gaither, personal communication, March 20, 2012).

However, there are treatment goals consistent across references. In reference to children, treatment is aimed at reducing or eliminating social ostracism, treatment of other psychopathology, and prevention of GID in adulthood (GID Reform Advocates, 2008b; Zucker & Bradley, 1995). According to Zucker and Bradley (1995), social ostracism is more problematic with boys:

Clinical experience amply indicates that cross-gender-identified children, particularly boys, are frequently ostracized by their peers...Such ostracism, which can be very intense, often results in alienation, social isolation, and associated behavioral and emotional difficulties...Thus, treatment interventions aimed at reversing a child's cross-gender identification may not only alleviate short-term social distress by healing the child to mix more readily with same-sex peers, but may also prevent the development of longer-term psychopathological sequelae. (p. 266)

In therapy for adult clients, the main goal is “to alleviate the distress ... that was the reason that we gave the diagnosis to begin with. For some people, that’s a matter of coming to terms with who they are and... deciding on what might be an appropriate way to live their life” (G. A. Gaither, personal communication, March 20, 2012). In addition to alleviating distress, more recent therapy focuses on affirming an individual gender identity for the client (G. A. Gaither, personal communication, March 20, 2012; Yarber, Sayad, & Strong, 2010). This is contrary to one critic of the diagnosis that stated the current diagnosis supported “gender-conversion therapies intended to change or shame one’s gender identity or expression,” though they did not define what this entailed (Winters, 2008).

The actual therapy is dependent on the client. As previously mentioned, intake interviews are recommended and typically done to better form a treatment plan. A therapist can also give a provisional diagnosis “if somebody looks like they meet the criteria, but you still need some further information to be able confirm basically that they meet all the criteria that they need” (G. A. Gaither, personal communication, March 20, 2012). Dr. Gaither explained the general process of treatment:

Typically, we do an intake assessment. Most people tend to do some sort of intake and kind of get a sense of what’s going on with the person. At the Counseling Center, we typically don’t create a treatment plan until at least after the third session, and when we do the treatment plan, that’s when we also give the diagnosis. And so for us at the Counseling Center, that’s typically when we would give the diagnosis, other places vary. Some people, especially in private practice, need to have a diagnosis to be able to be reimbursed by an insurance company, and so they may actually give the diagnosis in their very first session...all in all, the treatment is really about decreasing the distress the person’s experiencing (personal communication, March, 20, 2012).

Though therapy is recommended prior to and after any medical treatments (Yarber, Sayad, & Strong, 2010), it should be noted that psychotherapy is not required for other, often medical, treatments.

Real-Life Experience. Real-life experience, or presenting oneself as their desired gender, is typically recommended before any kind of surgery (G. A. Gaither, personal communication, March 20, 2012). This not only allows for the individual to be comfortable with their decision, but also begin the process of learning their new gender. Gender socialization, or

learning one's gender, occurs throughout childhood (Yarber, Sayad, & Strong, 2010). Crawford (2012) stated that a man becoming a woman would need to "not only dress like a woman; he should also walk, sit, talk, flirt, sip coffee, and throw a ball like a woman" (p. 142). Living as the other gender with its respective mannerisms, movements, etc. is a complex process that must be relearned (Yarber, Sayad, & Strong, 2010). The individual must also get comfortable in this new role. Wassersug et al. (2007) had a male-to-female transsexual report, "I spent almost a year going out in public and getting comfortable with myself as a woman, working with my presentation, my voice, my mannerisms, makeup and dress" (as cited by Crawford, 2012, p. 142). Kessler and McKenna (1978) added that it is possible to pass as the opposite sex without surgery because interactions rely primarily on social cues (as cited by Crawford, 2012).

Crawford (2012) elaborated on this point by saying:

Passing is much more a matter of fulfilling social expectations for a man or woman than having male or female genitals...Innumerable small differences in verbal and nonverbal behavior mark gender in social interaction. A man who becomes a woman must not only dress like a woman; he should also walk, sit, talk, flirt, sip coffee, and throw a ball like a woman. To pass as a woman, s/he should have feminine interests and activities. And s/he must learn how to respond when treated like a woman (p. 142).

In addition to altering their behaviors, individuals will change their physical appearance as well. For instance, "a woman may change her sex appearance by binding her breasts and getting a man's haircut. A man may wear makeup and women's clothes and strap his penis between his legs" (Crawford, 2012, p. 142). Over a period of time, changes in appearance and social behaviors can allow one to drastically change their gender presentation.

Hormone Therapy. Hormone therapy is one of the biological treatments available to individuals. It is also the second step for candidates who choose to get SRS, which is usually preceded by one or two years of hormone therapy (Gaither, 2011). Estrogen and androgens also allow individuals to get secondary sex characteristics (Crawford, 2012), such as feminine breasts and body hair reduction on males and muscle bulk and voice deepening for females. Hormone therapy is also more ideal for female-to-male transsexuals (FTMs) because phalloplasty, or the creation of a functioning penis, has not been perfected yet (Devor, 1997, as cited in Crawford, 2012; Gaither, 2011). The associated medical risks and costs of SRS could also be avoided for individuals who choose to just use hormones.

Surgery. It is possible for individuals with GID to change their anatomy and other physical features to match that of their preferred gender. This can be completed using various medical procedures, including SRS, breast augmentation, breast reduction, and other treatments (Winters, 2008; Yarber, Sayad, & Strong, 2010). Surgery differs slightly for MTF and FTM clients. For a MTF transsexual, the vaginal cavity is created using skin from the penis as well as some tissue from the colon. Other tissue from inside the penis, the corpus spongiosum, will form the clitoris. Tissue from the scrotum is converted into the inner and outer labia. MTF transsexuals often choose to get other procedures aside from SRS, such as electrolysis and a tracheal shave. As previously mentioned, hormones are taken prior to and after surgery (Yarber, Sayad, & Strong, 2010). For FTM transsexuals, the process of constructing a penis is more complex. After testosterone therapy, the clitoris is enlarged enough to be refashioned into a penis, and the labia forms the scrotum. However, in order to achieve a penile erection, a surgical implantation of either a rod or inflatable device is necessary. FTM transsexuals typically get a mastectomy, a hysterectomy, as well as their ovaries removed (Yarber, Sayad, & Strong, 2010).

Much like the MTF transsexuals, hormone therapy is necessary before and after surgery. Postoperative follow up is encouraged (Yarber, Sayad, & Strong, 2010). There is mixed research over whether SRS and other medical surgeries actually relieve gender dysphoria. The GID Reform Advocates (2008a), Winters (2008), and Yarber, Sayad, and Strong (2010) state that SRS is the most appropriate treatment to alleviate the distress. Yet, in the Udeze et al. (2008) study using pre- and post-surgery MTF transsexuals, no significant differences arose in the participants' psychological functioning after their surgery. Udeze et al. continued by stressing that more research was necessary to see the long-term effects of SRS (as cited in Crawford, 2012).

Recommended Treatments

Psychotherapy. Multiple sources recommended some type of counseling before pursuing other more permanent treatments in order to cultivate an acceptance of the client's identity. Psychotherapy may address any distress the client is experiencing and give them the appropriate coping skills if necessary. Therapy can also provide a client with mental preparation before they alter their body, if they choose to, and discuss their reasoning for surgery, what they should expect before and after surgery, etc. For example, therapy is recommended as a necessary "step along the way" if clients want sex reassignment surgery (G. A. Gaither, personal communication, March 20, 2012). Yarber, Sayad, and Strong (2010) recommended long-term follow up therapy after surgery as well.

In the cases of child clients, the individual may or may not have fully formed their gender identity, thus more intrusive procedures are not recommended. "I think that, in many cases, especially in early childhood, we'd really want to give some time to make sure that this is who

the person really sees themselves as.” (G. A. Gaither, personal communication, March, 20, 2012). Oddly enough, the rates for children with GID that will continue to show symptoms in adulthood are low (GID Reform Advocates, 2008b). GID is, however, associated with homosexuality in adulthood (Zucker & Bradley, 1995). Attempting to avoid adult homosexuality is considered “problematic” (Zucker & Bradley, 1995), and also unethical by today’s standards.

An intake interview was recommended across sources in the initial stages of therapy for both children and adults (G. A. Gaither, personal communication, March 20, 2012; Zucker & Bradley, 1995). Zucker and Bradley (1995) state that a clinical interview allows the therapist to see “the presence of gender dysphoric feelings and confusion about his or her status as a boy or girl” (p. 70). Also, the interview may be helpful in planning future treatment. At Ball State University’s Counseling Center, an intake interview is typical and treatment plans are created after at least three sessions (G. A. Gaither, personal communication, March 20, 2012). This allows for a more accurate diagnosis and individualized treatment plan.

Real-Life Experience. Real-life experience, or living as one’s preferred gender, is an essential part of the process to transitioning (G. A. Gaither, personal communication, March 20, 2012; Yarber, Sayad, & Strong, 2010). Adults with GID are usually required to present themselves as the opposite sex prior to medical surgery. This is to ensure they are comfortable with living as the opposite gender before more permanent changes occur (G. A. Gaither, personal communication, March, 20, 2012).

Ironically, one of the critiques of GID is that treatment actually reinforces the idea that one must conform to a gender because there are only two sexes and two genders (Crawford,

2012). Furthermore, “their dilemmas of identity may be a result of our binary system of sex and gender. Indeed, the criteria for a diagnosis of GID are entirely based on a binary model” (Golden, 2008, as cited in Crawford, 2012).

Medical Treatments. Opponents of the GID diagnosis stated that hormonal and medical treatments, such as surgery, were well proven to relieve gender dysphoria and distress (GID Reform Advocates, 2008a; Winters, 2008). Furthermore, the diagnosis “undermines the legitimacy of sex reassignment [surgery]” (GID Reform Advocates, 2008a; Winters, 2008). Similarly, Yarber, Sayad, and Strong (2010) stated that majority of individuals who had SRS reported it as the most appropriate treatment for those with extreme gender dysphoria. However, it should be noted that the research is mixed over whether SRS relieves psychological distress (Udeze et al., 2008, as cited in Crawford, 2012; Winters, 2008).

Conversely, not all sources recommended medical treatment for GID. According to Dr. Gaither, recommending that treatments “depend on the particular individual. What is their reason?” (personal communication, March, 20, 2012). Dr. Gaither also gave an instance of when surgery would be considered inappropriate:

There are, and I don’t think it’s very many, but I think that there are, at times, some gay men that basically have said to themselves, ‘It’s not okay to be gay.’ If it’s not okay to be gay, but I’m attracted to men, what can I do? Well, make myself a woman or at least make my body feminine. And so, if that’s what really what it’s all about, I think that in many cases like that, it may make a lot more sense to work with them to decrease the internalized homophobia, become comfortable with the fact that they’re gay. Because,

again, there's so many risks involved in this [SRS], and they're gonna change their body (personal communication, March, 20, 2012).

One film that details a situation such as this is *Hedwig and the Angry Inch*. Trask and Mitchell (2001) detail the life of a character living in Berlin during the Cold War. In order to leave the country with his partner, an American soldier, he must undergo sex reassignment. However, the non-gender dysphoric character receives a botched operation, which causes even more psychological distress. Dr. Gaither compared it to body dysmorphic disorder. Surgery may not relieve the psychological distress an individual has and should not be considered the only option. He explained:

You have to weigh out these things for a person to really be happy and whole, basically. In their own mind, they need to be out of the environment they're in, but there's no mechanism in place other than a reassignment surgery, but you can see with a botched surgery just what an awful impact it has on a particular person's life. (personal communication, March 20, 2012).

Criteria for Diagnosis or Treatments

DSM Diagnostic Criteria. The current diagnostic criteria for GID is in DSM-IV-TR. This diagnosis can be given to both children, adolescents, and adults. The prospective DSM-V will have the criteria for Gender Dysphoria, with some modifications made to the diagnosis.

Current GID Diagnosis in DSM-IV-TR. In order to be diagnosed with GID in adults or adolescents, the client must identify as the opposite gender, which may include passing as the other sex. They also display discomfort of their gender roles and physical features associated with their sex. This is also accompanied by psychological distress or impairment in their life.

The physical intersex condition excludes an individual from being diagnosed with GID (Behavenet, 2012; GID Reform Advocates, 2008a). For a more detailed list of diagnostic criteria for GID in adults and adolescents, see Appendix A.

In children, clients may insist that they are the other sex, prefer opposite gender roles and dress, and prefer playmates of the opposite gender. Children may also show disgust towards their genitalia. Similarly, there must be psychological distress or impairment for the child, and the child cannot have the physical intersex condition (Behavenet, 2012; GID Reform Advocates, 2008b). For a more extensive list of diagnostic criteria for GID in children, see Appendix B.

Gender Dysphoria Diagnosis for Prospective DSM-V. Adults or adolescents with gender dysphoria identify themselves as the opposite gender. They may have a strong desire to get rid of their anatomy and secondary sex characteristics of their assigned gender. They will desire to be the opposite gender, as well as have the opposite gender's primary and/or secondary sex characteristics. They may believe that they have typical feelings of the other gender, and wish to be treated as a member of the opposite gender. Furthermore, the client must experience psychological distress or impairment. There is no exclusion criterion for individuals who have a disorder of sexual development, but this is considered a subtype of Gender Dysphoria (American Psychiatric Association [APA], 2011a). To see a more in depth list of criteria for Gender Dysphoria in adults/adolescents, see Appendix C.

In children, there is an incongruence between their assigned gender and gender identity. They may insist that they are the other gender and engage in cross-dressing. They may prefer opposite gender roles, games, or toys and prefer playmates of the opposite gender. And, in addition to a dislike of their anatomy, they may desire to have primary and/or secondary sex characteristics of the opposite gender. This condition is associated with some kind of

psychological distress or impairment. Finally, there is no exclusion criterion for children with a disorder of sexual development, but this is considered a subtype of Gender Dysphoria (APA, 2011b). For a more detailed list of criteria for the new diagnosis in children, see Appendix D.

GID versus Gender Dysphoria. One of the more distinct differences in the current and prospective diagnosis is the inclusion of disorders of sex development, which can also be termed intersex. A person who is intersex has sexual anatomy that is ambiguous or atypical male and female anatomy (G. A. Gaither, personal communication, March 20, 2012; Yarber, Sayad, & Strong, 2010). In previous editions of the DSM, there was a debate over whether to include the intersex condition. For example, in the DSM-III, “an intersex condition was an exclusion criterion for the adult diagnosis of transsexualism; however, it was not an exclusion criterion for gender identity disorder of childhood” (Zucker & Bradley, 1995, p. 51). When the DSM-III Revision came out, the exclusion criterion was eliminated for the adult diagnosis of transsexualism (Zucker & Bradley, 1995).

Debate Over Psychological Distress/Impairment. Opponents of the GID diagnosis state that the GID diagnosis is given even when individuals are not distressed or impaired (GID Reform Advocates, 2008a; Winters, 2008). The GID Reform Advocates (2008b) went even further in saying that high-functioning children have been given the diagnosis as well. This contradicts other literature and the criterion of the diagnosis itself, both of which state that significant distress or impairment in various areas of the individual’s life must be present (Behavenet, 2012; G. A. Gaither, personal communication, March 20, 2012; Kamens, 2010; Yarber, Sayad, & Strong, 2010; Zucker & Bradley, 1995).

Opponents have also had issues with the term GID, as it had implications that gender variant people were disordered (GID Reform Advocates, 2008a). This probably resulted in the

name change of the diagnosis to gender dysphoria, which implicates that psychological distress occurs.

Client Profile. As previously stated, a treatment plan is based on the client's individual needs. A treatment plan differs especially between adults and children. For instance, the leading standards of care manual for gender dysphoria strongly recommends against any kind of physical treatment for clients under the age of sixteen (Gaither, 2011). Age can also determine whether or not the diagnosis is given at all. Dr. Gaither elaborates that "[in] a very young child, you obviously wouldn't give the diagnosis because it's [his/her identity] not really stable yet" (personal communication, March 20, 2012).

Clients also need to meet the criteria of the diagnosis, which will enable them to certain kinds of treatment (G. A. Gaither, personal communication, March 20, 2012). This includes having some kind of impairment or clinically significant distress (Behavenet, 2012). Often for children, this may manifest itself in school or at home. If there are no issues for the child, it is unlikely that their parent or guardian would take them in for counseling.

Recommendations for medical treatments can be based on the psychological stability and reasons for surgery. Dr. Gaither elaborates:

I think that I would look at the individual, look at their rationale or reasons for wanting the surgery. There are a number of people, and this goes for a lot of different kind of things, like we look at Body Dysmorphic Disorder, right? There's a lot of people that believe that "If I just get my nose fixed," for example, that my whole life is going to get better. And, you know, there are people that have really unrealistic expectations for the outcome of sex reassignment surgery. And I think that we'd want to be clear with them

about that. It's part of the reason for having them live that life a little bit beforehand (personal communication, March 20, 2012).

When a client sees a psychologist, they typically require them to live as the opposite sex for at least a year before any surgeries (G. A. Gaither, personal communication, March 20, 2012). As noted earlier, an individual also must complete hormone therapy prior to and after surgery (Gaither, 2011).

If a client is not seeing a psychologist, they could still get hormone therapy or medical surgery. However, there are medical factors that can impact that as well.

Do they have a substance-related problem that may make things really difficult? Do they have other health issues? And these are things that the doctors, as opposed to myself, the medical doctors would be looking into. Are there any kind of conditions that a person has that would making having such a surgery, potentially life threatening because of that? Do they really understand what it's gonna take to be able to maintain their body? (G. A. Gaither, personal communication, March 20, 2012).

Finally, an individual needs to have the financial resources, or perhaps appropriate insurance coverage, to pay for all treatments associated with this diagnosis.

Insurance Coverage. Though BSU's insurance provider is not representative of all insurance companies, it allowed this study to see an example of what treatments would or would not be covered. This, in turn, could demonstrate that treatments is available only to individuals financially fortunate enough to afford them. According to Brandi McGlothlin, the Manager of Employee Benefits at Ball State University:

All [health plans] have a general exclusion section in them that exclude coverage and state that no benefits are payable for “services and supplies for a sex change.” This is only one of several exclusions made by our plans including among other things, in vitro fertilization and weight loss surgeries. Regarding therapy/mental services, it is possible that this type of treatment could be covered if the medical coding done by the physician is vague and does not specify that the therapy is for the purpose of gender reassignment. Our drug plan does not exclude hormones, so it is possible that the hormones could be covered (as long as no prior authorization rules are put into place for this class of drugs)...Legal gender does not affect access to hormones through our prescription benefit. It’s my understanding that sometimes testosterone is prescribed to females for the treatment of breast cancer, so blocking the access to hormone based on legal gender would be an impediment to other types of therapy (personal communication, April 5, 2012).

Thus, according to this insurance provider, the only treatment that is covered is hormone therapy. However, unless there was a preexisting condition where the hormones are needed, like breast cancer for testosterone, it seems like access to the hormones may be more complicated. Psychotherapy is not covered unless there was a coexisting psychopathology, such as depression. The GID Reform Advocates (2008a) reported similar information when they stated that SRS is “easily dismissed as “elective” and “cosmetic” by insurers.” This contradicts information from Dr. Gaither, who stated that the diagnosis was necessary to be reimbursed by an insurance company (personal communication, March 20, 2012).

It should be noted, however, that this is information is only from one provider. Thus, this information cannot and should not be generalized to insurance companies as a whole.

Outcomes

Upon review of this information, several interesting outcomes emerged, particularly with the potential effects of this diagnosis. These effects not only impact the individuals who are diagnosed with GID, whom are exposed to prejudice and stigma, but also the organization who authors the DSM, the APA, whose methodology is called into question.

Unintentional Prejudice. Because society's view of gender is very dichotic, it becomes difficult for many people to accept gender variant individuals. Many individuals still associate gender with one's genetic, or chromosomal, sex. Because of this, many transgendered people are misunderstood and stigmatized (Yarber, Sayad, & Strong, 2010). Opponents of the diagnosis, such as GID Reform Advocates (2008a; 2008b), HRC (2009), Kamens (2010) state that the GID diagnosis pathologizes variant sexual behavior or that it "literally implies a "*disordered*" gender identity" (GID Reform Advocates, 2008a). The HRC (2009) explained that, "Much of the distress that many transgender and other gender non-conforming people feel comes not from within, but from outside – from the prejudice that is directed against them by people who don't understand them or don't want to." Though unintentionally, clinicians can be biased as well. Dr. Gaither mentioned:

I think that there's a lot of people that may see more problems than are actually there. As psychologists, we still have our individual biases, which, we should, through our training, be able to identify our biases and understand what kind of impact it has, but there's a lot of people that aren't necessarily as in touch with their biases (personal communication, March 20, 2012).

What is more difficult to determine is whether prejudice towards the transgender community occurs because of the GID diagnosis. The GID Reform Advocates (2008a) argue that it enforces negative and false stereotypes; however, such language can be seen as rhetorical because the criteria states distress or impairment must be present (G. A. Gaither, personal communication, March 20, 2012). Gaither continued is saying that prejudice results from the individuals being deviant, in the sense that they violate social norms. It is also possible that those who are prejudice towards the transgender community may not even have knowledge of the DSM or the GID diagnosis (G. A. Gaither, personal communication, March 20, 2012). The diagnosis may be influenced by current social norms, much like homosexuality formerly being in the DSM, but the causal relationship between the diagnosis and prejudice cannot be inferred.

Psychiatric Stigma. Like other psychopathologies, GID also carries the negative stigma associated with mental illness. Critics and proponents alike address the fact that stigma is associated with mental illness and, in turn, GID. The GID Reform Advocates (2008a), Winters (2008), and Yarber, Sayad, and Strong, (2010) mentioned the psychiatric stigma and labeling is an issue associated with GID. Dr. Gaither elaborated by saying, “Just like with any psychiatric diagnosis, the idea that you’re mentally ill or unstable if you have a psychiatric diagnosis, it could possibly cause problems” (personal communication, March 20, 2012). Because the transgender community already has stigma resulting from a violation of gender norms, the additional stigma associated with mental illness is a concern. However, this is unavoidable until the stigma towards mentally ill persons changes.

Concern Over DSM’s Direction. One of the major concerns related to the DSM is the lack of research and validity associated with the GID diagnosis and corresponding treatments. Crawford (2012), Gaither (2011), the GID Reform Advocates (2008a; 2008b), the Society of

Indian Psychologists (2011), and Zucker and Bradley (1995) all stated that research surrounding the GID diagnosis was limited, conflicting, or weak. The Society of Indian Psychologists (2011) described many concerns towards the prospective DSM-V, primarily with methodology. Such complaints included:

- Disregard of the vast literature on the role of cultural context and mental illness
- Referencing Field Trials that were finalized before the Field Trials
- Sampling bias in the Gender and Cross-Cultural Issues Study Group
- Disregard for socio-economic and cultural influences on behavior for the gender dysphoria diagnosis
- Absence of political, social, and cultural contributions towards mental health
- Absence of other mental health disciplines, apart from psychiatry, in the DSM-V's Task Force, Study Groups, and Work Groups, all of which develop the manual
- No systematic studies done for determining the clinical validity of gender dysphoria and gender dysphoria in children
- Inclusion of children and adolescents for gender dysphoria diagnosis without adequate research
- Lack of research of clinical utility outside of psychiatry
- Sampling bias for Field Trials which ignore rural ethnic populations
- Sole use of structured interviews which contradicts multicultural literature

Additionally, Dr. Gaither was troubled by the inclusion of the intersex condition for the diagnostic criteria:

I think it [the inclusion of intersex condition] raises huge concerns. Like, somebody that's born with ambiguous genitalia, what is their sex? What is their gender? Well, it's assigned to them. And so, they've got potentially a disorder of sexual development. Now we're going to give them a gender identity disorder because they identify differently than the doctor did when they first pulled them out of the womb. I mean, it's saying that the doctor's assigned gender diagnosis was correct and this kid is wrong. Right? And that there's a problem there. And so, you know, I think that that speaks about this the whole diagnosis maybe to begin with (personal communication, March 20, 2012).

Past editions of the DSM, such as the DSM-IV, had issues with empirical evidence and diagnoses. According to Zucker and Bradley (1995), the prevalence of GID in children, expressions of dislike for their sexual anatomy, changes in the incidence of GID, and the underlying biological influences for GID were unknown or needed more exploration. This is a continuing problem with the current DSM-V and will continue until adequate and valid research is done.

Preliminary Findings

Language varies according to audience and intent. For both opponents and proponents of the GID diagnosis, language use in references greatly varied. Typically, proponents of the diagnosis came off as more informed or educated in psychopathology and psychology. The language was usually neutral in tone, and the speaker did not seem to be aggressive or antagonistic. The intent seemed to be to inform.

Opponents of the GID diagnosis usually used very vague language. The language also did not seem academic or use much psychology jargon. The tone of the language was not neutral. It was often negative and seemed very reactive. This could indicate that their intention was not to provide information about the diagnosis, but rather, persuade other individuals to rally against the diagnosis. The exception was the professional complaint issued from the Society of Indian Psychologists (2011). In the complaint, much less reactive language was used. The content also differed, and the complaint centered around their concerns on the scientific rigor of various diagnoses, including GID. Though the intent seemed to be to persuade individuals, the Society of Indian Psychologists wrote their letter to Dr. David Kupfer, the chair of the DSM-V Task Force. It seems more advantageous to use a logical argument than an emotional one. Conversely, for people with little knowledge of sound methodology, research and clinical validity, and psychology/psychiatry, perhaps individuals could be more easily swayed with an “emotional” type of argument.

Prejudice may not result directly from the DSM. Prejudice towards the LGBTQ community, particularly the transgender community, is not likely to come from this diagnosis itself. It is probable that people who are prejudice against the transgender community are less familiar with or even unaware of the DSM or this particular diagnosis. The prejudice likely results from a violation of gender norms in our society. However, this does not mean that the diagnosis is completely unrelated to norms and prejudice. Much like egodystonic homosexuality, which emerged after homosexuality was removed from the DSM in 1973 (G. A. Gaither, personal communication, March 20, 2012), the diagnosis and relative therapies appear to be moving in a direction where the principal aim is to relieve the psychological distress in the

individual. Total elimination of the diagnosis is unlikely because of this. However, there is some potential progress.

Generally, there was no concern regarding the inclusion of the intersex condition.

No concern was evident, via the internet, of the inclusion of intersex condition in the new diagnosis. The intersex condition has previously been included and excluded from this diagnosis (Zucker & Bradley, 1995). Only one reference, Dr. Gaither, showed concern towards this inclusion. Perhaps this results from being unaware of its inclusion or the terminology. Additionally, the intersex condition is only seen listed as a subtype, where the exclusion criteria was previously listed in the actual diagnosis. In the prospective DSM-V, it does not state one way or another whether the disorder of sexual development refers specifically to the physical intersex condition, but what raises concern is the absence of the criterion that previously excluded the physical intersex condition.

New Research Questions

Many questions existed after this project's completion. There remain questions about research, ethicality, insurance coverage, and actual clients. Because I did not have access to any individuals diagnosed with GID, my new research questions would relate to them. Such questions would include the following:

- What is your understanding of what the DSM is?
- What is your understanding of what GID is? (*If unfamiliar with the GID diagnosis, individual would be provided with a copy of the DSM-IV-TR diagnosis*)
- Is there a criterion that does accurately represent your life experiences?
 - In what ways does this criterion match up with your life experiences?

- Are there any more?
 - In what ways do they match up?
- Is there a criterion that does not accurately represent your life experiences?
 - In what ways does this criterion not match up with your life experiences?
 - Are there any more?
 - In what ways do they not match up?
- Are you comfortable with the criteria and diagnosis from the DSM?
 - Can you put into words why you are comfortable or uncomfortable?
- Are you familiar with the new Gender Dysphoria diagnosis? (*If unfamiliar with the GID diagnosis, individual would be provided with a copy of the DSM-V Gender Dysphoria Diagnosis*)
 - Do you feel that this more accurately reflects your life experiences than the GID diagnosis?
 - How so?
 - If not, why?
- What is your understanding of what the physical intersex condition is? (*If unfamiliar, individual would be provided with definition of physical intersex condition*)
 - Should gender dysphoric individuals who are physically intersexed be given this diagnosis?
 - Why or why not?
 - Does this differ from individuals who do not have the physical intersex condition?

- In some cases, the doctor will alter the genitalia of a child at birth if their sexual anatomy is ambiguous, essentially “assigning” their gender. If this person was gender dysphoric, should they still be given this diagnosis?
 - Why or why not?
- (Providing samples from Society of Indian Psychologists, GID Reform Advocates, and interview with Dr. Gaither)
- Which of these arguments appeals to you the most?

Source A.: They reinforce false, negative stereotypes of gender variant people and at the same time fail to legitimize the medical necessity of sex reassignment surgeries (SRS) and procedures for transsexual women and men who urgently need them. The result is that a widening segment of gender non-conforming youth and adults are potentially subject to diagnosis of psychosexual disorder, stigma and loss of civil liberty (GID Reform Advocates, 2008a).

Source B.: This is, in some sort of way, a gateway to the kinds of treatment. People from the transgender community may say, ‘It’s taking away our civil rights.’ But, if you don’t have a mechanism to get the sex reassignment surgery that you’re after, than I’m not sure that I see it that way. Again, the idea at least is that there is some sort of distress that’s related to it...I’m looking at the diagnosis criteria, and criterion D says that “the disturbance causes clinically significant distress or impairment in social, occupational, or other areas of functioning” ...You cannot give the diagnosis without a person meeting that criterion (G. A. Gaither, personal communication, March 20, 2012).

Source C.: The clinical validity of a number of diagnoses is in question, even by the DSM-5 Work Groups (as stated on the web-site descriptions). For example, there have been no

systematic studies to determine the clinical validity of: ...Gender Dysphoria, Gender Dysphoria in Children (Society of Indian Psychologists, 2011).

- What parts of the source's argument make it appealing to you?
- Are any of these arguments unappealing?
 - What makes them less appealing to you?
- How does this information affect your opinion about GID?
 - Do any of the sources change your opinion of GID?
 - What would a source need to say to change your opinion about GID?
- Did you find any of these sources difficult to understand?
 - What made them difficult to understand?
 - Did this effect how much the source did/did not appeal to you?
- Can you tell me about your more memorable experiences where you felt discriminated against based on your gender identity?
 - Can you tell me some ways that you coped with that discrimination?
- Have you felt discriminated against by an organization because of your gender identity?
 - Did this differ from discrimination by another person?
 - How did it differ?
 - What are some ways you coped with that discrimination?
 - Did you cope differently in this situation?
 - How so?
- How does your insurance cover any payments associated with GID? (Psychotherapy, hormone treatments, surgery, etc.)
 - Which treatments are covered through your insurance?

- Which treatments are not covered through your insurance?
- Can you tell me how expensive (not very expensive, manageable, expensive, very expensive) your treatments have been?
- Is access to any treatments more difficult because of your insurance plan?

Finally, if I were to continue research on this topic, I would attempt to improve this study by collecting information from a greater variety of sources, especially focusing on those with first-hand experience. Ideally, these sources would include the following: people from the medical community (both doctors and psychiatrists), individuals who have had SRS, individuals who have done hormone therapy, and people who have had neither SRS nor hormone therapy. I would try to speak with representatives from multiple insurance companies to see if and how coverage differs from BSU's insurance plan. Such sources would allow me to further examine treatment factors and costs, the treatment processes, and people who have directly been impacted by this diagnosis.

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Appendix A

Diagnostic Criteria for GID in Adolescents or Adults.

- A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.
- B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.
- C. The disturbance is not concurrent with a physical intersex condition.
- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if (for sexually mature individuals) Sexually Attracted to Males, Females, Both, Neither.
(Behavenet, 2012; GID Reform Advocates, 2008a).

Appendix B

GID Criteria for Children.

- A. In children, the disturbance is manifested by four (or more) of the following:
1. repeatedly stated desire to be, or insistence that he or she is, the other sex
 2. in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
 3. strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
 4. intense desire to participate in the stereotypical games and pastimes of the other sex
 5. strong preferences for playmates of the other sex
- B. In children, the disturbance is manifested by any of the following:
1. in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games and activities;
 2. in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.
- C. The disturbance is not concurrent with a physical intersex condition.
- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if (for sexually mature individuals) Sexually Attracted to Males, Females, Both, Neither (Behavenet, 2012; GID Reform Advocates, 2008b).

Appendix C

Gender Dysphoria (in Adolescents or Adults).

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by 2^{*} or more of the following indicators: [2, 3, 4]**

1. a marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics) [13, 16]
2. a strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics) [17]
3. a strong desire for the primary and/or secondary sex characteristics of the other gender
4. a strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
5. a strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
6. a strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of suffering, such as distress or disability**

Subtypes

With a disorder of sex development [14]

Without a disorder of sex development

See also: [15, 16, 19]

Specifier**

Post-transition, i.e., the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is undergoing) at least one cross-sex medical procedure or treatment regimen, namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male, mastectomy, phalloplasty in a natal female). (American Psychiatric Association [APA], 2011a).

Appendix D

Gender Dysphoria (in Children).

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by at least 6* of the following indicators (including

A1): [2, 3, 4]

1. a strong desire to be of the other gender or an insistence that he or she is the other gender (or some alternative gender different from one's assigned gender) [5]
2. in boys, a strong preference for cross-dressing or simulating female attire; in girls, a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing [6]
3. a strong preference for cross-gender roles in make-believe or fantasy play [7]
4. a strong preference for the toys, games, or activities typical of the other gender [8]
5. a strong preference for playmates of the other gender [9]
6. in boys, a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; in girls, a strong rejection of typically feminine toys, games, and activities [10]
7. a strong dislike of one's sexual anatomy [11]
8. a strong desire for the primary and/or secondary sex characteristics that match one's experienced gender [12]

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of suffering, such as distress or disability.**

Subtypes

With a disorder of sex development [14]

Without a disorder of sex development] (APA, 2011b).

Appendix E

Interview Questions for Dr. Gaither.

1. What is your understanding of what Gender Identity Disorder (GID) is?
2. In your opinion, under what conditions could you see yourself applying this diagnosis to an individual?
 - a. What is your understanding of when and how this diagnosis is applied by professional counselors and clinicians?
 - b. What are some advantages of this diagnosis?
 - c. What are possible problems from giving this diagnosis?
3. At what point during treatment would you apply this diagnosis for an individual? (Is there a standard “time” to apply it?)
4. Would the age of the individual be an important variable in your assessment?
 - a. If so, could you please explain how and why it would impact your assessment?
 - i. Would the assigned gender of the child be an important variable in your assessment? If so, how would this be handled based on the assigned gender?
 - ii. Would the assigned gender of an individual, regardless of age, be an important variable in your assessment? If so, how is this handled based on their assigned gender?
 - iii. Do you think the assigned gender of the individual would make a difference in the stress level, and in turn the psychological distress, of the individual? (Why or why not?)

5. Is there specific training or workshops required (for psychologists/counselors, that you're aware of) in order to give a diagnosis of GID?

i.e. Would you have to specialize in GID in order to give the diagnosis?

6. One of the complaints raised by the Human Rights Campaign (HRC), which is an organization that works to achieve civil rights for the LGBT community, was the presence gender identity disorders in the DSM is very similar to homosexuality (prior to 1973).

They stated that this diagnosis not only impacts the health and well-being of transgender people, but also “the civil rights of the transgender community and all people.”

- a. What parts of this position are valid? (Why?)
 - b. What parts of this position are invalid and would have negative outcomes? (Why?)
 - c. Do you believe that removing GID from the DSM would decrease bias and prejudice towards the transgender community? (Why or why not?)
 - d. Do you believe that keeping GID in the DSM would decrease biases or prejudices towards the transgender community?
 - e. (or) In your opinion, does this diagnosis prevent true equality for the transgender community? (Why or why not?)
7. The HRC also stated that much distress from gender non-conforming people comes from their environment, rather than “from within” (or from their “non-traditional” gender identification).
- a. What parts of this statement do you believe are valid? (Why?)

- b. What parts of this statement do you believe are invalid and have negative outcomes? (Why?)
8. One complaint raised by GID Reform Advocates (from gidreform.org) questioned the validity and consistency (as well as fairness) of the GID diagnosis. They also stated that the revisions of the DSM “reinforce false, negative stereotypes...and at the same time fail to legitimize the medical necessity of sex reassignment surgeries (SRS)...the result is that a widening segment of gender non-conforming youth and adults are potentially subject to diagnosis of psychosexual disorder, stigma and loss of civil liberty.”
 - a. What parts of this statement do you believe are valid? (Why?)
 - b. What parts of this statement do you believe are invalid? (Why?)
9. Another complaint from GID Reform Advocates is that the diagnosis for GID in children is overinclusive and questions the therapeutic purpose of GID in children.

-They stated, “The diagnostic criteria for GID of children were significantly broadened in the DSM-IV...[and] is clearly not limited to egodystonic subjects. High functioning children may be presumed to meet criteria A and B on the basis of cultural nonconformity alone...Thus, a child may be diagnosed with GID without ever having stated any desire to be the other sex. Most puzzling, the DSM-IV-TR admits that: ‘Only a very small number of children with GID will continue to have symptoms that meet criteria for GID in adolescence or adulthood (p. 579).’”

 - i. What parts of this statement do you believe to be valid? (Why?)
 - ii. What parts of this statement do you believe are invalid and have negative outcomes? (Why?)

10. Would you recommend SRS (sexual reassignment surgery) for any individual diagnosed with GID?
 - a. What factors would influence you to recommend that treatment?
 - b. What other treatment options are available? (i.e. How would this treatment be handled differently?)
 - c. Would the assigned gender be an important variable in recommending treatment for the client? (Why or why not?)
11. What are the main objectives for treatment of GID?
 - a. Would attempting to conform the individual to their assigned gender ever be considered a treatment option? (Why or why not?)
12. One complaint raised by the Society of Indian Psychologists (in a letter to Dr. David Kupfer) is that GID lacks multicultural validity. The study group only had one woman and no Native American members. Additionally, it was unclear which cultural principles were considered (including socioeconomic status)
 - a. What parts of this argument do you believe to be valid? (Why?)
 - b. What parts of this argument do you believe to be invalid? (Why?)
 - c. Do you believe it would still be ethical to apply this diagnosis to ethnic minorities (given the issues with sampling)?
 - i. How could this be considered inappropriate?
 - ii. How could this be considered appropriate?
13. The Society of Indian Psychologists also stated that gender dysphoria (a diagnosis that often coincides with GID) has not been adequately researched for clinical validity.
 - a. What parts of that statement are valid? (Why?)

- b. What parts of that statement are invalid? (Why?)
14. I have previously learned that gender is considered to be a continuum. If gender is a continuum, does GID contradict that idea? (That there should be a “normal” gender?)
- a. Why or why not?
15. Kate Bornstein is a figure in the transgender community that wrote a guide an individual “to their own gender.” Would role models such as her have positive effects on individuals from the transgender community? (Why or why not?)
16. Would raising the awareness for the general public to transgender issues be effective in alleviating some of the distress that accompanies GID?
- a. Why or why not?
17. On the website for the proposed revisions for the fifth DSM, they had a subtype that was “with or without a disorder of sexual development.” Is a disorder of sexual development another term for “intersex”?